PRINTED: 11/06/2014 FORM APPROVED

<u>Divisior</u>	of Health Care Fac	cilities_		FORM APPROVI			
STATEMEN AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING		(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
		TN0504			11/0		
NAME OF I	PROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, STATE, ZIP CODE		11/03/2014		
KINDREI	NURSING AND RE	HABILITATION-Ma 1012 JAN	TESTOWN W.	AY			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLE DATE	
ion of Hea	1200-8-608 (17) Building Standards (17) The licensed contractor shall not install a system of water supply, plumbing, sewage, garbage or refuse disposal nor materially alter or extend any existing system until the architect or engineer submits complete plans and specifications for the installation, alteration or extension to the department demonstrating that all applicable codes have been met and the department has granted necessary approval. (a) Before the nursing home is used, Tennessee Department of Environment and Conservation shall approve the water supply system. (b) Sewage shall be discharged into a municipal system or approved package system where available; otherwise, the sewage shall be treated and disposed of in a manner of operation approved by the Department of Environment and Conservation and shall comply with existing codes, ordinances and regulations which are enforced by cities, counties or other areas of local political jurisdiction. (c) Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at shower, bathing and hand washing facilities shall be between 105°F and 115°F. This Rule is not met as evidenced by: Based on testing and interview, it was determined that the facility failed to provide hot water at each hot water a		N 847	<u> </u>		y this ently and 319	
RATORY I	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE	TITLE	.1/	X6) DATE	
E FORM	ner ve	CUD, NO, 10/47T	99 089	 RO21	If continuation	8/14	

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Division	of Health Care Fac	ilities			FORM	APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
<u> </u>	TN0504		B. WING			11/03/2014	
NAME OF A	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE, ZIP CODE				
KINDREI	D NURSING AND RE	HABILITATION-Ma 1012 JAN	JESTOWN W	AY			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	D.BE COMPLETE	
	at 3:15 p.m. confirr maintained betwee rooms 302, 312, ar temperature was 8 1. Interview with the regional maintenant 2014 at 3:15 p.m. continued without hot water disystem problem that has been aware of appropriate actions services to implement plumbing system. These findings were director and acknowledged.	erview on November 3rd, 2014 med the hot water was not in 105 and 115 degrees. In and 319 the hot water	N 847	DEFICIENCY)			
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